South Texas Risk Management Model
Decision making based on clinical indicators

Moderate to severe cognitive problems: Veterans who demonstrate the inability to learn new skills or grasp new material. Retention deficits are a key concern. Patients suspected of such problems should be referred to Psychiatry for assessment.

Moderate to severe dementia: Patient safety becomes an issue with this involvement. There may also be issues regarding ability to learn.

Moderate to severe psychological/psychiatric disorders: Veterans need to be able to function in a residential training setting. If there is the potential for behavior problems, or be active drug and alcohol abuses residential setting may not be the best way to approach rehab services. Veterans with a history of going AMA need to be carefully screened before considering an application. Openly expressed racism constitutes a concern. The perception of race in different eras has changed. This bias could be found offensive or be a stressor. The issue of openly expressed racism is deeper then just a psychological disorder.

Functional computer users: Veterans who can demonstrate the ability to functionally use a computer to meet outcome goals should not be referred to a BRC for mere issuance. It is likely these numbers will grow with the aging of computer literate "baby boomers."

Referral to meet the Coordinator's needs: The push for numbers can override judgment in referral of cases to a BRC.

Severe PTSD: PTSD often includes sleep disorders and other actions that can be detrimental to success in a BRC type setting. Return to a military like environment could prove a stressor, especially if there is not adequate intervention to address this and other issues.

NOTE: The estimates of PTSD in Vietnam veterans range up to 30%. This is a concern that will only grow in the future.

Treatable eye conditions: The easiest cases to relate to are individuals with diabetes who are totally unregulated. Often eyesight improves once a treatment regimen has been established. Cataracts are another instance where vision might be restored. There are other conditions where vision might be improved.

Veteran is care provider: The veteran may have alternatives to resolve care considerations. However, if separation anxieties are

going to interfere with training then this may also be a consideration in alternative training modes.

Veteran unwilling to attend a BRC: This may be attributed to numerous reasons. It is important that training candidates are willing to attend. It is also important that a continuum of services be developed locally and through the VA.

Blind Rehabilitation Training

When we make a referral our applications go the BRC located in Waco Texas. Waco is a 15 bed BRC. Waco offers a regular blind rehabilitation Program, a computer access training program and a dual program. Dual does not mean two separate programs. Dual is usually when a veteran has minimal needs in one specific program, usually the regular blind rehabilitation program, so needs in the other area are filled.

Waco, like every other BRC, manages it's own waiting lists. Many veterans refuse admission when initially asked to attend. This occurs in other BRCs as well. No one has done a study of why veterans refuse. It is counterintuitive that people who have been waiting on a list for months would refuse entry into a training program. They do not want their names removed from the waiting list for the program. We can only speculate on reasons. We think they include things such as:

- Not enough lead time notification to prepare to go
- Specialty appointments pending at the home VA
- Family events
- Veterans with minimal commitment
- Veterans who have second thoughts after agreeing to go
- Veterans who continue to restore functions while waiting and see decreased need
- Veterans who did not really want to go, but agreed to please their VIST Coordinator

Waco works with us on cases that we identify as critical. Normally these are cases that involve impending health or school issues. The clearest cases are those involving impending dialysis. Often there is a small window of opportunity and both sides have to work to make the connection for the veteran.

South Texas Risk Management Model
Decision making based on clinical indicators

Blind Rehabilitation Service uses outpatient priority status to direct admissions in to a BRC. Since BRCs are inpatient programs, we feel that a triage system much like surgical triage should be used in the future. The most imperative cases would be addressed first and minor cases (the equivalent of elective surgery) would be done in a lower priority manner.

VIST and BROS generate reports to the BRC to help in the evaluation process. When possible, they participate in team meetings. There may be follow-up care needed that is part of discharge planning. We try to send a follow-up report for every veteran to the BRC to document efforts in reintegration into the home environment.

Shortening of the Waiting List

In the past year we have made a conscious effort to make sure that every referral is an appropriate one. The first reaction is that we are not sending veterans who need to go. This is not the case. We have made the conscious effort not to convince veterans to go unnecessarily. We have moved to a more clinically based model. We believe the veteran has to have a valid rehabilitation need to be admitted into a hospital. It needs to be determined based on clinical indicators that the veteran's needs cannot be adequately met in the local community. A referral is part of our long term planning with the veteran and his/he families. We realize that referring veterans who do not require inpatient care clogs the system and slows and perhaps prevents other veterans from be admitted. Since we firmly believe that services delayed are services denied there is a strong commitment to provide the right services at the right time and in the proper setting.

Conclusion:

Historically Blind Rehabilitation Service and its network of hospital-based programs reflected the rest of the VA (and private health care providers). Services were inpatient and hospital based. Historicaliy the only way to get blinded veterans the services they required was to refer them to a BRC. Past VA eligibility rules led to little incentive to develop and implement services in the community. In those days veterans were subjected to long waits, often over a year, before they were able to attend a BRC. It was only after this wait that they were able to receive needed treatment and prosthetics. The desire for optical devices drove many veterans to agree to attend a BRC. The

limited scope of service provision included only the few who could gain admission and denied services to the vast majority of blinded veterans. This system went on for years. When Dr. Kaiser converted the VA to an outpatient model it provided the opportunity for thousands of blinded veterans to receive needed services for the first time. This trend continues and we view ourselves as part of this trend. Only in the continuum of services model can we sustain our Risk Management model of care. This model has the flexibility to provide a wide array of timely services that can provide a continuum of care for all blinded veterans.

It seems clear to us that every attempt needs to be made to provide restorative rehabilitation services to veterans in the least restrictive environment possible for all blind veterans. The goal of all intervention is to reduce risk factors, restore lost function, foster independence, and improve the veteran's quality of life.

PRESENTATION TO VA CARES COMMISSION

BY

WALTER SCHELLHASE

Henry B. Gonzales Convention Center
200 E.
San Antonio, Texas
1 October 2003

I am Walter Schellhase, President of the Hill Country Veterans Council. The Council represents over 16,000 veterans in the Texas Hill Country. Thank you for the opportunity to speak to you reference the CARES initiative as the process relates to the Kerrville Division of the STVHCS.

Members of your team have visited the Kerrville facility on at least two occasions. Therefore, you know the excellent condition of these facilities, the truly dedicated professional staff providing care to our veterans and the timeliness of service the veteran receives. Therefore, I will not go into telling you about the excellent facility we have in Kerrville. However, I will tell you about the desire of veterans through out South Texas choosing to make use of this facility as opposed to all others in the system. It is a well know fact that Veterans in South Texas will go the extra

mile to obtain their medical health care in Kerrville when allowed to do so. Up until a few years ago, Kerrville was known as the very best in VA health care service. There had to been a reason for such desire on the part of the veteran to come to Kerrville.

Several years ago bad decisions were made reference acute beds, specialty services, surgery, and who will and who will not be entitled to VA service. The VA has a unique way of making the stagtistics reflect the numbers the system wants to see. As an example, this year you want the numbers to reflect usages. Therefore, service is extended to all categories of veterans. Next year you want to reflect a lack of usages. Therefore, you cut off service to a particular category. Lets face it, the VA is not providing the veterans with the service our veterans deserve and yet you cut or, in the case we are here today to discuss, enhanced realignment. Enhanced Realignment is NOT a bad term to use when you are trying to sale a product to congress. However, in real terms, it means reduced service to our Hill Country veterans,

regardless of what you say. In fact at a recent briefing by one of your team members the statement was made, “we are not trying to close down anything, we are trying to justify keeping the small rural hospitals open”. We do not consider Kerrville a small rural hospital. The fact that the VA has selected to discontinue much of the services provided in the past, in the desire to achieve budget goals, does not mean these services are not still needed, it just means they are no longer available to the needed veteran in this particular area.

It has been stated that CARES is not intended to diminish any health care now being provided our veterans but to enhance that service by realigning the assets. If I understand your charge correctly from Secretary Principi, you are to evaluate the capital assets the VA now has and realign those assets to provide better health care to our veterans. Actually, I see the proposal by VISN 17, as a cost cutting proposal and will not in any way provide better health care to our veterans. How will closing the Waco Hospital,

the only psychiatric facility in Texas, enhance that vital service to our veterans? Especially when there is no stated plan as to how these beds will be replaced. How will closing the acute beds in Kerrville enhance the health care to the veterans in the Texas Hill Country and South Texas?

Has there been any effort by your Commission to figure out how to realign our assets to enhance the veterans health care service by reducing the waiting time for an appointment, reduce the waiting time to see a doctor, make specialty services readily available, provide specialty personnel when needed, such as urologists, audiologists, ophthalmologists, orthopedics and the list goes on. It certainly appears your Commission, if accepting the recommendations of VISN 17, is heading in a cost saving direction but not enhancing the health care of our veterans.

Lets look at the Kerrville hospital. Ten years ago there was over 300 active beds, with specialists for most needed conditions with, surgery and an excellent team approach to veteran's health

care. Today we have 5 ICU and 20 acute beds. Now VISN 17 proposes to change the 20 beds remaining from acute to transitional. Has anyone in the VA bureaucracy ever wondered where those 280 veterans, needing acute beds, have gone for medical care?

In the STVHCS statistics plan presented to the Veterans Council last December there was projected a continuing decrease in veterans count from now until 2022. As a veterans group we challenged these numbers as being grossly inaccurate. For the hearing held in Temple last July the data provided by VISN 17 show a substantial increase in requirements for primary care in South Texas from a 2001 base line of over 212,000 to nearly 278,000 in 2012 and then a slight decreasing to a little over 256,000 in 2022. At the same time, specialty care is expected to continue to increase over the years by 53% in the year 2022. I am not sure why 17's figures differ so much from those used by STVHCS in December. The interesting thing is, how can STVHCS

justify recommendation of Alternative A (Status Quo) with a projected decrease in patient load where VISN 17 recommends Alternative D with a substantial increase in patient count.

All of these projected figures are based on no additional military contingents occurring. Well that has not happened. We now have veterans of the current conflict in the Middle East and other conflicts around the world. The world situation is obviously adding to our veteran needing medical care and makes the numbers stated earlier flawed. Respiratory problems, pneumonia, ventilator dependency units are just a few of the additional challenges we face as the results of current conflicts – all requiring acute beds.

VA started closing beds in our area (both Kerrville and Audie Murphy) several years ago and opening clinics. Opening clinics through the catchment area of each VA facility provided a tremendous service for the veteran. Many veterans that have never used a VA facility started to receive medical care at one of these clinics. It is a well-known fact that local clinics provide an

additional input to the requirements of acute beds. For roughly every 20-40 outpatients seen in a clinic at least one patient will require an acute bed. However, when that veteran is referenced to the hospital for an acute bed, the bed is not available. You can provide all the clinics you want, but if you do not maintain the hospitals to support the clinics, you have provided the veteran a terrible disservice.

STVHCS director has stated on more than one occasion that we have gone too far in closing acute beds. And now, if I read the current proposal correctly, the VA wants to open more clinics throughout the STVHCS area adding additional needs for acute beds and at the same time, provide for the 20 Kerrville beds in San Antonio. Based on data presented by both VISN 17 and STVHCS it is obvious there is a need for more acute beds not less in the South Texas area. So the question I have to ask is, “why change acute to transitional in Kerrville”?

This is where it becomes difficult to understand VISN 17's recommendation. At the current time, when Audie Murphy's acute beds are full, the patient is sent to Kerrville and this is not unusual. When Kerrville acute beds are full, which is over 50% of the time, patients are sent to Audie Murphy. However, on at least four occasions in the past 90 days four patients were referred to Audie Murphy but no beds were available. One went to the local hospital at his own expense, one was sent to Methodist and the other two were held at Kerrville until a bed opened up at Audie.

When you look at VISN 17's recommendation under the comments column it notes: "Implement in coordination with San Antonio". To date, it appears no one knows exactly what this means other than "when proposed construction is completed" as stated in the VA news release. It would there is a large construction program planned for Audie Murphy that has been announced.

It would be a shame for the VA to consider any sort of expansion in San Antonio where the facility is land locked, parking a serious problem now and gets worst every day, and cost/BDOC is extremely high. This would truly be an injustice to the American taxpayer, especially when you have a facility in Kerrville with over 70 acres available for expansion, unlimited parking capability, an operation cost/BDOC of only $870, a staff that is recognized as one of the best throughout the area, and a facility that the veteran is willing to drive through San Antonio, by passing Audie, to be treated at the Kerrville facility.

If you really want to realign the assets to enhance the health care to our veterans how can you possibly not recommend:

1) Increasing the acute beds in Kerrville to a least 40 to relieve the pressure at Audie
2) Save hundreds of thousands of dollars in construction cost
3) Provide the American taxpayer the break they deserve
4) Make complete use of an excellent existing facility

5) Add back the needed specialist such as:

a. Surgery (now must go to Audie)

b. Urologist (waiting of over 80 days)

c. Orthopedic (now must go to Audie)

d. Podiatry appointments made in September will be scheduled in January

Making these recommendation will be putting our veterans first and realigning our assets to enhance veteran health care.

Yes, here are a lot of changes that need to be made in Kerrville, but acute beds to transitional beds is not one of them.

Thank you.

STATEMENT OF
WILLIAM J. MORIN
NATIONAL SERVICE OFFICER
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
CAPITAL ASSETS REALIGNMENT FOR ENHANCED SERVICES COMMISSION
SAN ANTONIO, TEXAS
OCTOBER 1, 2003

Mr. Chairman and Members of the Commission:

On behalf of the local members of the Disabled American Veterans (DAV) and its Auxiliary, we are pleased to express our views on the proposed Capital Assets Realignment for Enhanced Services (CARES) Market Plans for this area in VISN 17.

Since its founding more than 80 years ago, the DAV has been dedicated to a single purpose: building better lives for America's disabled veterans and their families. Preservation of the integrity of the Department of Veterans Affairs (VA) health care system is of the utmost importance to the DAV and our members.

One of VA's primary missions is the provision of health care to our nation's sick and disabled veterans. VA's Veterans Health Administration (VHA) is the nation's largest direct provider of health care services, with 4,800 significant buildings. The quality of VA care is equivalent to, or better than, care in any private or public health care system. VA provides specialized health care services—blind rehabilitation, spinal cord injury care, posttraumatic stress disorder treatment, and prosthetic services—that are unmatched in the private sector. Moreover, VHA has been cited as the nation's leader in tracking and minimizing medical errors.

As part of the CARES process, VA facilities are being evaluated to ensure VA delivers more care to more veterans in places where veterans need it most. DAV is looking to CARES to provide a framework for the VA health care system that can meet the needs of sick and disabled veterans now and into the future. On a national level, DAV firmly believes that realignment of capital assets is critical to the long-term health and viability of the entire VA system. We do not believe that restructuring is inherently detrimental to the VA health care system. However, we have been carefully monitoring the process and are dedicated to ensuring the needs of special disability groups are addressed and remain a priority throughout the CARES process. As CARES has moved forward, we have continually emphasized that all specialized disability programs and services for spinal cord injury, mental health, prosthetics, and blind rehabilitation should be maintained at current levels as required by law. Additionally, we will remain vigilant and press VA to focus on the most important element in the process, enhancement of services and timely delivery of high quality health care to our nation's sick and disabled veterans.

Furthermore, local DAV members are aware of the proposed CARES Market Plans and what the proposed changes would mean for the community and the surrounding area.

Our testimony will involve the Southern Market and Valley Coastal Bend Markets based on the 2001 Enrollment Statistical Projection. It appears 2012 and 2022 gap projections are fair actuarial projections given the census of that enrollment. However, we believe the enrollment census of 2001 may not reflect the accuracy of the veteran population needing medical services, especially in rural and highly rural areas. We believe there are at least 4 primary reasons for the calculation discrepancy, the down sizing of the military; the changes in law regarding herbicides and Gulf War related disabilities, especially diabetes and chronic fatigue syndrome; the rapidly growing need for mental health and specialty services; and the curtailment of enrollment in 2001, when it became apparent veterans could not reasonably be given timely medical services and care.

While we welcome the projected expansions and facilities, we remain concerned and vigilant regarding the necessity to adequately expand our medical personnel resources and specialty care.

We are concerned with projected closures of inpatient beds at the Kerrville VA Medical Center (VAMC) and the growing transfers of outpatient care to Audie L. Murphy VAMC and other contract facilities. While some changes may be interpreted as cost effective or necessary, these changes will undoubtedly create unreasonable burdens on "hill country" veterans living in rural and highly rural areas. It is 60 miles one way from the Kerrville VAMC to Audie L. Murphy VAMC and veterans living in the Kerrville VAMC area will be driving up to 150 miles (one way) for medical appointments.

The Coastal Bend and Rio Grande Valley areas have, for many years, experienced the lowest level of rationed medical care in this network, and while the actuarial projections support the needs for expanded services, we remain markedly concerned with the true economic commitment to this area. VISN 17 planning initiatives provide improvement in this area, however, to maintain that 35% of acute hospital demands will be treated at Audie L. Murphy VAMC *is not an improvement***.** The VISN 17 network proposal uses the Cameron County/Brownsville lease clinic is an enhancement supporting the new Harlingen Medical Facility; however, we received notification that the Brownsville Clinic will be closing in 2004.

Currently, the DAV Transportation Program in the Rio Grand area operates 2 vans (4 trips weekly) from the McAllen Clinic and the Harlingen/Brownsville area. Mileage from the McAllen Clinic is approximately 250 miles (one way) and 300 miles (one way) from the Brownsville area. Our dedicated volunteer staff must be lodged overnight due to the traveling distance, and *in reality our program is a band-aid on an arterial bleed (geographically, the distance traveled would be comparable to a veteran traveling from Washington, D.C. to New York City for medical care).* We believe serious consideration must be given to providing better economic and administrative commitment in this area.

Currently in San Antonio, Kerrville, Corpus Christi, and the Rio Grand Valley veterans are waiting 6 to 9 months for mental health services and many other specialized medical services. We believe without mandatory funding, VA medical services will continue to fall behind its already overburdened demand. Clearly

Congress needs to not only address the statistical projections but needs to know that *reasonable medical services should not be a political forum for those who fought to preserve the freedom our Country now enjoys.*

In closing, the local DAV members of VISN 17 sincerely appreciate the CARES Commission for holding this hearing and for its interest in our concerns. We deeply value the advocacy of this Commission on behalf of America's service-connected disabled veterans and their families. Thank you for the opportunity to present our views on these important proposals.

SAN ANTONIO

STATEMENT OF
DON SIMONS
THE AMERICAN LEGION
BEFORE THE
CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES
(CARES) COMMISSION
ON
THE DRAFT NATIONAL CARES PLAN

OCTOBER 1, 2003

Mr. Chairman and Members of the Commission:

Thank you for the opportunity today to express the local views of The American Legion on the Department of Veterans Affairs' (VA)'s Capital Asset Realignment for Enhanced Services (CARES) initiative as it concerns Veterans Integrated Services Network (VISN) 17. As a veteran and stakeholder, I am honored to be here today.

The CARES Process

The VA health care system was designed and built at a time when inpatient care was the primary focus and long inpatient stays were common. New methods of medical treatment and the shifting of the veteran population geographically meant that VA's medical system was not providing care as efficiently as possible, and medical services were not always easily accessible for many veterans. About 10 years ago, VA began to shift from the traditional hospital based system to a more outpatient based system of care. With that shift occurring over the years, VA's infrastructure utilization and maintenance was not keeping pace. Subsequently, a 1999 Government Accounting Office (GAO) report found that VA spent approximately $1 million a day on underused or vacant space. GAO recommended, and VA agreed, that these funds could be better spent on improving the delivery of services and treating more veterans in more locations.

In response to the GAO report, VA developed a process to address changes in both the population of veterans and their medical needs and decide the best way to meet those needs. CARES was initiated in October 2000. The pilot program was completed in VISN 12 in June 2001 with the remaining 20 VISN assessments being accomplished in Phase II.

The timeline for Phase II has always been compressed, not allowing sufficient time for the VISNs and the National CARES Planning Office (NCPO) to develop, analyze and recommend sound Market Plan options and planning initiatives on the scale required by the magnitude of the CARES initiative. Initially, the expectation was to have the VISNs submit completed market plans and initiatives by November, 2002, leaving only five months to conduct a comprehensive assessment of all remaining VISNs and develop recommendations. In reality, the Market Plans were submitted in April 2003. Even with the adjustment in the timeline by four months, the Undersecretary for Health found it necessary in June 2003, to send back the plans of several VISNs in order for them to reassess and develop alternate strategies to further consolidate and compress health care services.

The CARES process was designed to take a comprehensive look at veterans' health care needs and services. However, because of problems with the model in projecting long-term care and mental health care needs into the future, specifically 2012 and 2022, these very important health care services were omitted from the CARES planning. The American Legion has been assured that these services will be addressed in the next "phase" of CARES. However, that does not negate the fact that a comprehensive look cannot possibly be accomplished when you are missing two very important pieces of the process.

The American Legion is aware of the fact that the CARES process will not just end, rather, it is expected to continue into the future with periodic checks and balances to ensure plans are evaluated as needed and changes are incorporated to maintain balance and fairness throughout the health care system. Once the final recommendations have been approved, the implementation and integration of those recommendations will occur.

Some of the issues that warrant The American Legion's concern and those that we plan to follow closely include:

- Prioritization of the hundreds of construction projects proposed in the Market Plans. Currently, no plan has been developed to accomplish this very important task.
- Adequate funding for the implementation of the CARES recommendations.
- Follow-up on progress to fairly evaluate demand for services in 2012 and 2022 regarding long-term care, mental health, and domiciliary care.

VISN 17 – SOUTHERN AND VALLEY-COASTAL BEND MARKETS

The San Antonio VA Medical Center and the Kerrville VA Medical Center provide services to veterans throughout this market. Additionally, there are a number of Community Based Outpatient Clinics (CBOCs) scattered around, 13 in all, that also provide care.

Campus Realignment/Consolidation of Services/Small Facilities

The San Antonio VAMC is overcrowded and does not have the existing capacity to handle the current demand, much less the future increases. The DNP proposes to transfer inpatient services from Kerrville to San Antonio, "as space becomes available from the proposed inpatient construction at San Antonio". The American Legion fails to see why the transfer has to be done at all? The original VISN market plan stated that the costs are lower at this facility than at community hospitals. The VISN conducted an analysis based on CARES criteria and specifically evaluated whether the beds needed to be transferred to San Antonio. In fact, the analysis did not support the re-allocation of the Kerrville Division acute medical beds. Additionally, the VISN assessed the community capability of absorbing the demand and found it lacking.

The American Legion believes the proposal to transfer the beds is premature. With the nation at war, in a war that by all accounts is going to last a while, new veterans are entering the system every day. Who really knows how many in the end there will be?

Another proposal in the DNP is to convert Kerrville to a Critical Access Hospital (CAH). Again, we believe there is no need to convert, change the mission, realign, or transfer any services from the Kerrville Division.

Outpatient Services

The CARES data indicates an increasing demand for primary care and specialty care through FY 2022. The DNP proposes to meet this demand through construction, renovation, expansion of existing facilities, and contracting care.

The American Legion would like to point out that throughout the VISN there has been many proposals that involve a significant amount of money and time in order to see them to fruition. We insist that no veterans care be disrupted during this process. Some type of transition plan should be in place so veterans do not feel left out and put out by a process that is supposed to enhance their healthcare options and access.

Outpatient mental health is being integrated with primary care at all sites. We must ensure that this is a smooth transition and that the sites are equipped to handle the patients along with the mission.

Thank you for the opportunity to express the views of The American Legion on this very important issue.

PRESENTATION
before the
CARES Commission
San Antonio, Texas
October 1, 2003

by **Carlos Martinez**
President and CEO
American GI Forum National
Veterans Outreach Program, Inc.

Thank you for allowing me the opportunity to come before this commission and share with you some personal observations on this very important plan.

I am grateful that the CARES Commission established a format that allowed not only the major veterans service organizations to present their views on this restructuring plan, but also that it sought out the many smaller groups and individuals that can also contribute to the final plan. I commend you for this vision.

In my review of the draft plan I was amazed at how much thought went into each and every phase, into each element of the plan, and the fact that it is well organized so that one can easily understand the direction planned, and the factors that led to that planned direction.

The use of actuarial data is one of the vital elements that I found impressive. As a smaller organization, we can accumulate much anecdotal evidence, but it must still be validated with a more scientific approach, and that is what these actuarial projections give us to work with.

For a moment let me just share with the committee members, the feelings expressed by our organizational members on this plan. Mind you, this is thoughts in general about the revamping that CARES is undertaking, and not referencing specific points in the draft plan. In our anecdotal surveys, our membership expressed concerns about:

* losing more benefits - I'm sure you've heard this before, but veterans are vary wary of change, because of past experiences in losing benefits, and a general mind-set is that more will be lost as the number of veterans gets smaller. Lately however, I have heard from some that participated in some of the CARES sessions around the country , that they felt more comfortable with the process.

* (Another Concern) That the hospitals are going to be shut-down. While utilization of space is vital to the success of this plan, we support the idea of more CBOC,s. CBOC,s can serve many of the smaller communities, at a lesser cost.

* Another idea that arose from that discussion is that if some hospital are under-utilized the idea in the draft plan of making them into assisted living centers is very sound, and certainly needed. Additionally however, the American GI Forum would be in favor of converting some of that under-utilized space to create transition quarters like in the military. If hospitals become more specialized in acute inpatient care, veterans will have to travel to other cities for care, and families could use these transitional quarters to offer the support so vital at that time.

* The draft plan's evaluation of joint DOD/VA hospital systems is also supported by the American GI Forum. Recently, I had the opportunity to visit the joint hospital system in Anchorage, Alaska and it was a wonderful facility that did not distinguish priority between vets and the military contingency. Everyone was served equally, and obviously this coordination maximizes service to both communities.

* And, Finally, we urge the CARES Commission to consider the plight of the homeless veterans in their ultimate planning. Homeless veterans experience an array of problems, but mental illness is a major issue not easily dealt with in the community. Substance abuse, physical ailments, and other issues contributing to homelessness must be addressed over an extended

period, and some relief is being provided by the VA's Grant and Per Diem Program and other community based programs, but the mental illness can best be served by a VA treatment center.

I thank you for the opportunity, and I commend each and everyone of you for your continuing service to the veteran community. I feel confident that with this type of outreach going on around the country the veterans will benefit from the best possible plan that will push the VA hospital system to new heights in health care quality.

Thank you.

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